

FILED FEB 12 1945

Registration District No. 128

Primary Registration District No. 5462

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield,
(c) Name of hospital or institution Rt. 1 Springfield, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Years
In this community 1 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural
(d) Street No. Rt 1, Springfield,
(If outside city or town limits, write "RURAL")
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Lavander Lusk

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ellen Lusk 6. (c) Age of husband or wife if alive 10th. 1864 years

7. Birth date of deceased 11 November (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>1</u>	<u>7</u>hr.min.

9. Birthplace Unknown Tenn (City, town or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business James Lavander Lusk

12. Name Unknown Tenn.

13. Birthplace Sarah Isabelle (State or foreign country)

14. Maiden name Unknown Tenn.

15. Birthplace Mrs. Norman Scott (State or foreign country)

16. (a) Informant Rt. 1, Springfield, Mo.

(b) Address Burial (b) Date thereof 12-31, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Plesant View Cemetery

18. (a) Signature of funeral director W. L. Dunn

(b) Address 629 W. Walnut, Springfield, Mo.

19. (a) Feb. 8, 1945 (b) Mrs. Porter O'Neil (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27 year 1944 hour 11 minute -- P. P. M.

21. I hereby certify that I attended the deceased from 19.....; that I last saw h..... alive on 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia Duration 48 hrs.

Due to.....

Due to.....

Other conditions Senile Hypertension
(Include pregnancy within 3 months of death)
Chronic Prostatitis

Major findings: Of operations.....

Of autopsy..... 107

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature C. E. Feller (M. D. or other).....

Address Springfield, Mo. Date signed 12/29/44

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED
Health Office,
Health Office,

NOV 5 1971

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *C. D. McCallister*

Licensed Embalmer No. *2891*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.